Recommendation for handling applications for
Insurance Affordability Programs (IAP)
During the first three months of the Initial Open Enrollment Period
October 1, through December 31, 2013

The purpose of this document is to provide a recommendation on how to handle Insurance Affordability Programs (IAPs) as defined in Affordable Care Act (ACA) during the first three months of the Open Enrollment Period of October 1 – December 31, 2013, with the specific emphasis on MAGI Medi-Cal (MC).

The final Exchange rule of 45 CFR §155.410 (see Appendix A) defines the initial open enrollment period for Qualified Health Plans (QHPs) through Advance Payment Tax Credit/Cost Sharing Reduction (APTC/CSR) programs and Unsubsidized Health Plans. The proposed rules issued on January 14, 2014 42 (CFR §435.1205 & 457.370) seek to ensure that consumers submitting single streamlined applications during the initial open enrollment period (October – December 2013) will receive MAGI-based eligibility determination for all IAPs and if eligible be able to enroll effective January 2014. This includes MAGI Medicaid/CHIP programs.

Assumptions

- Applications for MAGI Medi-Cal for January 2014 (during the first three months of the open enrollment) will only be taken/processed via CalHEERS
- CalHEERS Web Portal, paper applications and Covered California Service Center are the only access channels for Insurance Affordable Programs (IAPs) applications during this period
- eHIT interface between CalHEERS and SAWS will start operating on January 1, 2014
- Pre-ACA MC rules are not available in CalHEERS. Rules are only available in SAWS
- MAGI MC rules will be executed during this period for the purpose of determining eligibility for January 2014. MAGI MC results are displayed to consumers on the CalHEERS Web Portal and Consumers are only notified about the eligibility for January 2014 (see specific outcomes and scenarios below)
- CalHEERS consumer education and help pages will inform the consumers about Medi-Cal program changes, initial three months of the open enrollment and their options and choices for applications for Pre-ACA Medi-Cal during this period

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- **CalHEERS Web Portal, Paper Applications and Phone Applications via Covered California Access Channel.**
    - Consumers applying via CalHEERS (web, paper or phone) and interested in pre-ACA Medi-Cal application will be provided with the link to SAWS self-service portals home/starting umbrella page www.benefitscal.com where they can apply for pre-ACA Medi-Cal.
    - Consumers determined eligible for MAGI Medi-Cal for January 2014 will be sent to SAWS in January 2014 via e-HIT process
    - CalHEERS will hold on sending the final MAGI Medi-Cal NOA to consumers until the case is transferred to SAWS (and SAWS sends the disposition transaction with "ownership change" information). In the meantime, Consumers will get a general approval letter from Covered California informing them that their eligibility for Medi-Cal for January 2014 is pre-approved and unless circumstances change, they will get an official Approval NOA in January 2014
    - Consumers found pre-approved for MAGI Medi-Cal for January 2014 will be informed that if they apply for pre-ACA Medi-Cal in between (October-December 2013) and found eligible for no share of cost Medi-Cal (that meets Minimum Essential Coverage), that their pre-approved MAGI Medi-Cal will no longer be applicable. The next time their eligibility will be re-evaluated with ACA rules will be at their annual re-determination/Renewal in 2014.

- **SAWS Access Channel**
    - Paper Single Streamlined Applications for Insurance Affordability Programs (IAPs) received in the County Welfare Department offices will be:
        1. Used for pre-ACA Medi-Cal application (and supplemented with MC 210 for other information) if the consumer decides to apply for pre-ACA Medi-Cal.
            i. If the Consumer is approved for pre-ACA Medi-Cal, no action is necessary for processing through MAGI Medi-Cal rules. The eligibility is valid for a year (or less if the circumstances change).
            ii. If the Consumer does not qualify for pre-ACA Medi-Cal, the single streamlined application is sent to Covered California Service Center for processing in CalHEERS, or Eligibility Workers assist the consumers in applying via CalHEERS Web Portal
        2. If the consumer does not choose to apply for pre-ACA Medi-Cal, , the single streamlined application is sent to Covered California Service Center for processing in CalHEERS, or Eligibility Workers assist the consumers in applying via CalHEERS Web Portal

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Recommendation

- Educational messaging targeted for consumers seeking subsidized coverage:
  - Definition of Insurance Affordability Programs (IAPs) and open enrollment effective dates
  - Applications for IAPs (MAGI Medi-Cal, APTC/CSR) program eligibility available October 1, 2013 for the coverage effective date January 1, 2014
  - Consumers interested in pre-ACA Medi-Cal coverage may apply through their local Health & Human Services Agency (HHSA). (Link to the website www.benefitscal.com)
- Consumer's options for applying for Medi-Cal
  - Applicant chooses to apply for pre-ACA MC
    1. CalHEERS displays the link to www.benefitscal.com website and IAP application is not initiated
  - Applicant chooses to apply for IAPs
    1. CalHEERS determines IAPs eligibility. Possible outcomes:
       A. Applicant passes MAGI MC test
          1. Not tested for APTC/CSR
          2. Eligibility Result: ***'Eligible for MAGI Medi-Cal effective January 1, 2014'***
          3. Additional Messages:
             - ***'If you want to apply for pre-ACA Medi-Cal before January 2014 click here*** www.benefitscal.com***'***
             - ***'If you get approved for no share of cost pre-ACA Medi-Cal, MAGI Medi-Cal pre-approval will no longer apply'***
       B. Applicant fails MAGI MC test and passes APTC/CSR test
          1. Eligibility Result: ***'Eligible for APTC/CSR'***
          2. Consumer proceeds to Plan Selection and Enrollment pages
          3. Additional Message: ***'If you want to apply for pre-ACA Medi-Cal before January 2014 click here*** www.benefitscal.com***'***
       C. Applicant fails both MAGI MC and APTC/CSR tests
          1. Eligibility Result: ***'Not eligible for APTC/CSR'***
          2. Reason: ***'Above 400% FPL'***
          3. Next Steps: Tested for Unsubsidized Health Care and if eligible – asked if they want to purchase the insurance
          4. Additional Message: ***'If you want to apply for pre-ACA Medi-Cal before January 2014 click here*** www.benefitscal.com***'***

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Recommendation for business process for IAP Applications received during Initial Open Enrollment Period between October 1 and December 31, 2013:
CalHEERS Displays educational messaging for pre-ACA MC program eligibility determination
Consumer elects to apply for pre-ACA MC Program
Displays link to website www.benefitscal.com
IAP application not initiated
Consumer elects to apply for IAPs
IAPs application completed in CalHEERS
CalHEERS BRE runs IAP eligibility determination
Scenarios:
Consumer passes MAGI MC test

• Result: ***'Eligible for MAGI Medi-Cal effective January 1, 2014"***
• Additional Messages:
  ○ ***'If you want to apply for pre-ACA Medi-Cal before January 2014 click here*** www.benefitscal.com***'***
  ○ ***'If you get approved for no share of cost pre-ACA Medi-Cal, MAGI Medi-Cal pre-approval will no longer apply'***

• CalHEERS generates and sends General Approval Letter explaining that unless circumstances change, consumers will get an official MAGI Medi-Cal NOA in January 2014 • Message: If you want to apply to pre–ACA Medi-Cal before January 2014 go to www.benefitscal.com
Consumer fails MAGI MC test and passes APTC/CSR test
• Result: ***'Eligible for APTC/CSR'***
• CalHEERS generates and sends IAP Approval NOA (that explains not qualifying for MAGI Medi-Cal)
• Consumer enrolls in QHP effective January 1, 2014
Consumer fails tests for IAPs (MAGI MC and APTC/CSR)
• Result: ***'Not eligible for APTC/CSR'*** • Reason: ***'Above 400% FPL'*** • Additional Message: ***'If you want to apply for pre-ACA Medi-Cal before January 2014 click here*** www.benefitscal.com***'***
• CalHEERS determines eligibility to unsubsidized health care Unsubsidized eligible - CalHEERS authorizes
• CalHEERS generates and sends unsubsidized health care NOA and denial NOA for IAPs
• Consumer enrolls in QHP effective January 1, 2014

Appendix A

§ 155.20 Definitions.

Initial open enrollment period means the period during which a qualified individual may enroll in coverage through the Exchange for coverage during the 2014 benefit year.

§ 155.410 Initial and annual open enrollment periods.

(b) *Initial open enrollment period.* The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

(c) *Effective coverage dates for initial open enrollment period.*

(1) *Regular effective dates.* For a QHP selection received by the Exchange from a qualified individual—

(i) On or before December 15, 2013, the Exchange must ensure a coverage effective date of January 1, 2014;

(ii) Between the first and fifteenth day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month; and

(iii) Between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the Exchange must ensure a coverage effective date of the first day of the second following month.

(2) *Option for earlier effective dates.* Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraphs (c)(1)(ii) and (iii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (c)(1)(ii) or (iii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs, provided that either—

(A) The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or

(B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month for any month between December 2013 and March 31, 2014, the Exchange may provide a coverage effective date of the first of the following month.

NPRM § 435.1205 and 457.370

Coordinated Medicaid/CHIP Open Enrollment Process (§435.1205 and §457.370)

Under regulations at 45 CFR 155.410, during the initial open enrollment period starting on October 1, 2013, the Exchange will begin accepting a single streamlined application for enrollment in a QHP through the Exchange and for insurance affordability programs, with enrollment effective January 1, 2014. We are proposing a new §435.1205 to similarly provide that Medicaid and CHIP agencies begin accepting the single streamlined application during the initial open enrollment period to ensure a coordinated transition to new coverage that will become available in Medicaid and through the Exchange in 2014. Proposed §435.1205 implements several provisions of the Medicaid eligibility final rule effective October 1, 2013, and ensures the coordinated and simplified enrollment system for all insurance affordability programs envisioned in section 1943 of the Act and section 1413 of the Affordable Care Act. Our proposed rule seeks to ensure that no matter where applicants submit the single, streamlined application during the initial open enrollment period, they will receive an eligibility determination for all insurance affordability programs and be able to enroll in appropriate coverage for 2014, if eligible, without delay. In addition, under the proposed rule, states will need during the initial open enrollment period to facilitate a determination of Medicaid and CHIP eligibility based on the rules in effect in 2013 when a single streamlined application is filed. We provide states with several options to ensure that individuals can be properly evaluated for eligibility under the 2013 rules, to the extent applicable, as described below.

Proposed §435.1205 (a) incorporates certain definitions and references from the Medicaid eligibility final rule which are pertinent to proposed §435.1205. Proposed §435.1205 (b) provides that pertinent provisions of the Medicaid eligibility final rule, as modified in this proposed rulemaking, are effective as of October 1, 2013 for purposes of achieving alignment with the Exchange during the open enrollment period.

Under proposed §435.1205(c)(1), beginning October 1, 2013, state Medicaid agencies will accept (i) the single streamlined application used to make determinations for eligibility for enrollment in a QHP through the Exchange and all insurance affordability programs, or an alternative application developed by the state and approved by the Secretary per §435.907(b)(2) of the Medicaid eligibility final rule, and (ii) electronic accounts transferred from an agency administering another insurance affordability program, in accordance with 42 CFR 435.1200. We expect that utilization of the new single streamlined application will be in addition to, not in
lieu of any applications currently in use by the state Medicaid and CHIP agency to determine eligibility based on 2013 eligibility rules, but are open to discussion with states on transition options, discussed below.

In proposed §435.1205(c)(2)(i), we clarify that, beginning October 1, 2013, states must begin either (I) accepting determinations based on MAGI made by the Exchange for eligibility effective January 1, 2014 or (II) receiving electronic accounts of applicants assessed as potentially Medicaid eligible by, and transferred from, the Exchange, and determine eligibility for such applicants based on MAGI and the eligibility requirements to be in effect on that date. Whether the agency begins accepting Medicaid

eligibility determinations made by the Exchange or receives the electronic accounts of individuals assessed by the Exchange as potentially Medicaid eligible will depend on whether the agency has elected to delegate authority to the Exchange to make eligibility determinations under §431.10(c) of this rulemaking.

Per paragraph (c)(2)(ii), on October 1, 2013, state Medicaid agencies also will begin (I) making eligibility determinations for applicants submitting the single streamlined application to the agency, based on MAGI and eligibility criteria which will be in effect as of January 1, 2014, for coverage effective on that date and (II) assessing potential eligibility for enrollment in a QHP through the Exchange and for other insurance affordability programs for individuals determined not Medicaid eligible by the agency, and transfer the electronic account, including the application, to such other program, as appropriate. This ensures that electronic accounts for individuals determined potentially eligible for enrollment in a qualified health plan will be transferred to the Exchange in a timely manner so that eligibility for such enrollment as well as for advance payment of the premium tax credit and cost-sharing reductions can be determined by the Exchange and plan selection and enrollment can occur in time for January 1, 2014. Per proposed paragraph (c)(2)(iii), states also will need to provide notice and fair hearing rights consistent with part 431 subpart E of the regulations, as revised in this rulemaking, and §435.1200 of the Medicaid eligibility final rule, as also revised in this proposed rulemaking, regarding coordination of eligibility determinations, notice and appeals with the Exchange and with agencies administering other insurance affordability programs.

Proposed §435.1205 (c)(3)(i) provides that, for each individual determined eligible for Medicaid by the agency or the Exchange per proposed paragraph (c)(2)(i) or (ii), the agency must furnish Medicaid effective January 1, 2014. Per proposed paragraph (c)(3)(ii), the terms of §435.916 of the Medicaid eligibility final rule (relating to beneficiary responsibility to inform the agency of any changes in circumstances that may affect eligibility) and §435.952 of the Medicaid eligibility final rule (regarding use of information received by the agency) apply such that individuals determined eligible during the initial open enrollment period for coverage effective January 1, 2014 must report changes in circumstances that may affect their eligibility, and the agency must evaluate the impact of such changes on eligibility, consistent with §435.952. Under the proposed regulation, the agency has the option to schedule the first regular renewal under §435.916 for individuals applying during the open enrollment period and determined eligible effective January 1, 2014, to occur anytime between 12 months from the date of application and January 1, 2015. States may also conduct post-eligibility data matching to ensure continued eligibility as of January 1, 2014 and/or through the first regularly-scheduled renewal.

Given the outreach efforts anticipated around the single, streamlined application and the initial open enrollment period, some people who are eligible for Medicaid under 2013 rules can be expected to apply using the single, streamlined application. While Medicaid agencies are not required to adjudicate 2013 eligibility for applicants who apply using the single, streamlined application, we propose at §435.1205(c)(4) that states establish a process to ensure that individuals submitting the single streamlined application can be evaluated and determined eligible for coverage effective in 2013. States are encouraged, but not required, to determine eligibility effective in 2013 based on the information

provided on a single streamlined application, or to adopt a supplemental form or questions to obtain any additional information needed to do so. Specifically, we propose in 435.1205(c)(4)(i) that the agency may determine an applicant's eligibility for 2013 based on the information gathered as part of the single streamlined application if the agency has sufficient information to make such a determination, or request any additional information (through, for example, use of a supplemental form) needed to do so, providing notice and appeal rights in accordance with the regulations. Alternatively, per proposed §435.1205(c)(4)(ii), the agency may notify individuals submitting the single streamlined application during the initial enrollment period that to be considered for eligibility in 2013 they must submit a separate application for coverage and provide information on how to obtain and submit such application. We request comment on whether states should only notify a subset of applicants about the process to apply for coverage with an effective date in 2013 – for example only those applicants who appear, on the basis of available information provided on the single streamlined application, to be potentially eligible under 2013 rules.

Given the value of implementing a coordinated the eligibility and enrollment process for enrollment in a QHP through the Exchange and all insurance affordability programs during the initial open enrollment period, we are considering, for purposes of the initial open enrollment period, whether, in addition to proposed §435.1205 and §457.370, to make some or all of the following sections of the regulations, as promulgated or revised in the Medicaid eligibility final rule or as proposed or revised in this rulemaking, effective October 1, 2013, or whether an effective date of January 1, 2014 for some or all of these sections is appropriate: §431.10 and §431.11 (relating to the delegation of authority to the Exchange or Exchange appeals entity to determine eligibility and conduct fair hearings); §435.603 (MAGI-based methodologies) and §435.911 (MAGI screen) for purposes of making eligibility determinations effective prior to January 1, 2014 prior to that date; §435.907 (use of the single streamlined application); §435.908(c) (use of application assisters) and §435.923 (use of authorized representatives); §§435.940 et seq. (verification of eligibility criteria); §§431.200 et seq., §435.917 §435.918 and §435.1200 (coordination of eligibility and enrollment, notices and appeals between the Exchange, Medicaid and CHIP); and corresponding CHIP regulations in part 457 (§§457.315, 457.330, 457.340, 457.348, 457.350, 457.351, 457.380 and 457.1180). We solicit comments on the appropriate effective date for these sections to ensure a smooth initial open enrollment period.

We will also work with states interested in not having to assess eligibility during this limited time period based on two different sets of rules. For example, some states have expressed interest in using the authority of section 1115 of the Act to apply MAGI-based methods to determinations of Medicaid eligibility effective with the 2013 open enrollment period, or in more closely aligning current financial methodologies with MAGI-based methods
through adoption of less restrictive methods under their state plan. CMS is open to working with states to effectuate these or other ideas states or other stakeholders may have to achieve coordination with the Exchange and minimize administrative and consumer burden during the 2013 open enrollment period.

Finally, during the initial open enrollment period and likely at least through 2014, some individuals may submit the application used by the state to determine eligibility using 2013 rules. We seek comment on

the best ways for states to ensure that individuals submitting such applications during the initial open enrollment period are evaluated for coverage effective January 1, 2014, and thereafter, to ensure that state Medicaid agencies obtain such additional information as is necessary to determine whether such individuals are eligible for Medicaid using the MAGI-based standards, methodologies and eligibility categories for coverage effective
on January 1, 2014.

Like Medicaid, a separate CHIP program will need to align with the Exchange's initial open enrollment period. We propose a new §457.370 to apply the same provisions to states administering a separate CHIP as proposed for Medicaid at §435.1205.